Delaware Adult HIV Confidential Case Report Form

(Patients ≥ 13 years of age at time of diagnosis)

DATE ENTERED:

I. HEALTH DEPT USE ONLY

Document ID	Soundex Code	Report Status	Date Rec'd at DPH	State Number
DE00-		New Update	_____/_____/_____	
Document Source	**New Investigation**	**Report Medium**	**Surveillance Method**	
A_____-_____-_____-_____	Y N U		A F P R U	

II. PATIENT IDENTIFIER INFORMATION – *data not transmitted to CDC*

Patient Name: _____ Patient Alias: _____SS#: _____-_____-_____
last first middle

Current Address:_____

City: _____County: _____State: _____ Zip: _____ Phone: ( ) _____-_____

III. FORM INFORMATION

Date form completed:____/____/_____ Person completing form:_____ Phone: ( ) _____-_____

IV. CURRENT PROVIDER INFORMATION

Physician:_____Facility:_____
last first middle

City:_____ State:_____ Phone: ( )_____-_____

Med Rec No:_____

V. DEMOGRAPHIC INFORMATION – *complete ALL fields*

Diagnostic Status:
☐ Adult HIV
☐ Adult AIDS

Sex at Birth:
☐ Male
☐ Female

Date of Birth:
____/____/_____

Country of Birth:
☐ US ☐ US Depend/Posses
☐ Unk ☐ Other_____

Status:
☐ Alive
☐ Dead
☐ Unk

Death Date: ___/_____/_____
State/Terr of Death: _____

Marital Status:
S M W D Oth Unk

Ethnicity:
Hispanic ☐ Yes ☐ No ☐ Unk
Arabic ☐ Yes ☐ No ☐ Unk

Race (check all that apply):
☐ Black/AA ☐ White ☐ Asian ☐ Native American or Alaskan
☐ Hawaiian/PI ☐ Unk ☐ Other_____

Residence at Diagnosis: ☐ Same as Current Street Address:_____
City:_____ County: _____ State/Country: _____ Zip: _____

VI. FACILITY OF DIAGNOSIS

Facility Name:
Physician:

Address:
City:

State/Country:

Facility Type:
☐ Private Physician ☐ Hospital Inpatient
☐ Outpatient ☐ Emergency Department
Other: _____

VII. PATIENT HISTORY – COMPLETE ALL FIELDS

Before the 1st positive HIV test/AIDS diagnosis, patient had:	Y	N	U
• Sex with male			
• Sex with female			
• Injected drugs			
• Received clotting factor			
HETEROsexual relations with the following:			
• Injecting Drug User (IDU)			
• Bisexual male **(applies to females only)**			
• Person with hemophilia/ coagulation disorder			
• Transfusion recipient w/ documented HIV infection			
• Person with AIDS or documented HIV infection, risk unspecified			
Received transfusion Date 1st: / Date last: /			
Received organ transplant, tissue or artificial insemination			
Worked in healthcare/clinical laboratory **OCCUPATION:**			
Perinatally Infected			
Other:			

VIII. ADDITIONAL PATIENT OR DEMOGRAPHIC INFORMATION:

_____
_____
_____
_____
_____
_____
_____

COMPLETE REVERSE SIDE OF FORM →

IX. DOCUMENTED LABORATORY DATA

HIV ANTIBODY TESTS AT DIAGNOSIS: (**FIRST** known pos. test)

	RESULT			TEST DATE		
	Pos	Neg	Indet	Mo	Day	Yr
HIV-1 EIA						
HIV1/HIV2 EIA						
HIV1 Western Blot						
HIV2 Western Blot						

POSITIVE HIV DETECTION TEST: (**EARLIEST** known test)

☐ NAT ☐ p24 Antigen
☐ Qual PCR RNA ☐ Qual PCR DNA

VIRAL LOAD TEST: (**EARLIEST** & **MOST RECENT** tests)

Test Type:		COPIES/ML:	Mo	Day	Yr
00 NASBA *03 RT-PCR (stand)* *04 RT-PCR(ultrasen)* *05 bDNA - version 2* *06 bDNA – version 3*					

IMMUNOLOGIC LAB TESTS:

At or closest to current diagnostic status	Mo	Day	Yr
CD4 Count: _____ cells/ul (_____%)			
CD4 Count: _____ cells/ul (_____%)			
First <200 or <14% of total lymphocytes			
CD4 Count: _____cells/ul (_____%)			
CD4 Count: _____cells/ul (_____%)			

PHYSICIAN DIAGNOSIS:

If HIV lab tests were not documented, is HIV diagnosis documented by a physician? ☐ Yes ☐ No ☐ Unk

If YES, provide date of physician documentation	Mo	Day	Yr

X. AIDS INDICATOR DISEASES

Clinical Record Reviewed? ☐ **Yes** ☐ **No**

Disease:	**Initial Dx Date** (mo/day/yr)	Presumptive	Definitive
Candidiasis, bronchi, trachea, or lungs	____/____/____		☐
Candidiasis, esophageal	____/____/____	☐	☐
Cervical cancer, invasive	____/____/____		☐
Coccidioidomycosis, disseminated or extrapulmonary	____/____/____		☐
Cryptococcosis, extrapulmonary	____/____/____		☐
Cryptosporidiosis, chronic intestinal	____/____/____		☐
Cytomegalovirus disease (other than liver, spleen, or nodes)	____/____/____		☐
Cytomegalovirus retinitis (with loss of vision)	____/____/____	☐	☐
HIV encephalopathy	____/____/____		☐
Herpes simplex: chronic ulcers; or bronchitis, pneumonitis, or esophagitis	____/____/____		☐
Histoplasmosis, diss. or extrapulmonary	____/____/____		☐
Isosporiasis, chronic intestinal	____/____/____		☐
Kaposi's sarcoma	____/____/____	☐	☐
Lymphoma, Burkitt's (or equivalent)	____/____/____		☐
Lymphoma, immunoblastic (or equivalent)	____/____/____		☐
Lymphoma, primary in brain	____/____/____		☐
Mycobacterium avium complex or M. kansasii, diss. or extrapulmonary	____/____/____	☐	☐
M. tuberculosis, pulmonary	____/____/____	☐	☐
M. tuberculosis, diss. or extrapulmonary	____/____/____	☐	☐
Mycobacterium of other or unidentified species, diss. or extrapulmonary	____/____/____	☐	☐
Pneumocystis carinii pneumonia	____/____/____	☐	☐
Pneumonia, recurrent	____/____/____	☐	☐
Progressive multifocal leukoencephalopathy	____/____/____		☐
Salmonella septicemia, recurrent	____/____/____		☐
Toxoplasmosis of brain	____/____/____	☐	☐
Wasting syndrome due to HIV	____/____/____		☐

XI. TREATMENT/SERVICES REFERRALS

Patient informed of his/her infection? ☐ Yes ☐ No ☐ Unk

This patient's partners will be notified about their HIV exposure and counseled by:

☐ Local Health Dept
☐ Physician/provider

This patient's medical treatment is primarily reimbursed by:

HIV	AIDS	
☐	☐	Medicaid/Medicare
☐	☐	Private insurance
☐	☐	No coverage
☐	☐	Other public funding
☐	☐	Clinic trial/program
☐	☐	Unknown

	Yes	No	Unk
Is patient enrolled in a clinic/clinical trial? IF YES, name:_____			
Is patient receiving or been referred for:			
• HIV related medical services?			
• Substance Abuse treatment services?			
• Anti-retroviral Therapy			
• PCP prophylaxis			

XII. WOMEN ONLY

Is patient receiving or been referred for OB/GYN services?
☐ Yes ☐ No ☐ Unknown
If YES, physician_____

Is patient currently pregnant?
☐ Yes ☐ No ☐ Unknown
If YES, list EDC (due date) _____/_____/_____

Has patient delivered a live-born infant?
☐ Yes ☐ No ☐ Unknown
If YES, provide Grava____ Para____ & info below for most **RECENT** birth
Date of Birth:____/____/_____ Hospital of Birth:_____
City:_____ State:_____ Zip:_____
Child's Name:_____
last first middle

XIII. TREATMENT, REFERRAL OR OTHER COMMENTS:

_____

_____

_____